Montana Board of Medical Examiners
PO Box 200513
(301 South Park Avenue 4th Floor - Delivery)
Helena, MT 59620-0513
PHONE: (406) 841-2361 or (406) 841-2364 FAX: 406-841-2305
E-MAIL: dlibsdmed@mt.gov **WEBSITE:** www.medicalboard.mt.gov

ILLEGIBLE AND INCOMPLETE APPLICATIONS WILL BE RETURNED.

(PLEASE ALLOW A MINIMUM OF 10 DAYS FOR PROCESSING FROM THE DATE THE BOARD HAS A COMPLETE ROUTINE APPLICATION)

LICENSING REQUIREMENTS:

- Must be a graduate of a school of podiatry approved by the Board
- Must complete at least 1 year post-graduate training or have had equivalent experience or training approved by the Board (See Board Statute 37-6-302, MCA)
- Must have passed an examination administered by the National Board of Podiatry Examiners and be a diplomat of the National Board of Podiatry Examiners
- Must have obtained a score of at least 75% on all portions of the examination.
- Must be of good moral character

FEES: **$325.00 – Application Fee** ***Make payable to Montana Board of Medical Examiners***

PHOTOS: Attach one original photograph taken within the last year to page 3 and 7 of this application.

DOCUMENTS: The following documents must be submitted to the Board office in order to complete your license application. Please make 8 ½" x 11" copies of the following and submit with your application.

- **Certification of Podiatry Education**
- **Copy of Board Certification**
- **Proof of 1 year post-graduate Training**
- **Recent DEA Query Form**
- **DD214, Military Discharge Paper**
- **Recent National Practitioner Databank (NPDB) self-query (Letter Unopened)**
- **Current Verification from all State Licensing Boards**
- **Verification of Examination Scores**
- **FPMB Disciplinary Report**

NOTE: ALL DOCUMENTS NOT IN ENGLISH MUST BE ACCOMPANIED BY CERTIFIED TRANSLATIONS.

ADDITIONAL FORMS TO BE SUBMITTED FOR AN APPLICATION TO BE COMPLETE:

- **National Practitioner Data Bank (NPDB) self-query**. This form can be obtained by calling NPDB at 800-767-6732 or visit www.npdb-hipdb.com on the Internet. This form must be mailed directly to the address indicated in the instructions. The results will come to you; upon receipt please forward them to the Board office.
- **DEA Query form**. This form must be sent directly to the address indicated. The results will come directly to the Board office. There is no fee required.
- **FEDERATION OF PODIATRIC MEDICAL BOARDS.** You must complete this form and submit the required fee and form to the address indicated. The results will be mailed directly to the Board office. (This is to obtain the FPMB Disciplinary Report)
- **CERTIFICATE OF PODIATRY EDUCATION.** You must complete the bottom portion of page 7, including a current photo, in front of a notary and send the form to your podiatry school. The top portion of page 7 must be completed by school officials and sent directly back to the Board office.
- **VERIFICATION OF EXAMINATION SCORES.** You must request verification of your examination scores be sent directly to the Board office. Please contact the National Board of Podiatric Medical Examiners. For verification of Parts I and II please contact "The Chancey Group International" by calling toll-free (877) 302-8952. For verification of Parts III (PMLEXIS) please contact The FPMB by calling (561) 477-3060 or writing to: Federation of Podiatric Medical Boards, P O Box 740525 Boynton Beach, Fl 33474-0525.

APPLICATION PROCEDURES:

- When the application file is complete, it will be processed and considered by Board staff for permanent licensure. The applicant may be notified if additional information is required or if required to appear before the Board for an interview.
- If the application is considered a non-routine application, there may be a delay in processing of the application. You may be requested to provide additional information, or make a personal appearance before the Board during a regularly scheduled Board meeting and/or the application may require Board consideration. Non-routine applications may take 120 days to process.
- All verifications of licensure must be sent directly from each state board in which the applicant is currently or has ever been licensed. Please make copies of the attached verification request form as needed. Some states may charge a fee for verifications. Contact each state board prior to sending the request.
- Keep the Board office informed at all times of any address changes, changes in license status and complaints or proposed disciplinary action. This is essential for timely processing of applications and subsequent licensure.

PROCESSING PROCEDURES:

- An application file must be complete before consideration of licensure. The applicant will be notified in writing of any items missing from the application file.
- A routine application takes 10 days to process from the time it is complete.
- Please be sure the three individual references you listed on your application complete the reference questionnaire form and return the form directly to the Board office as soon as possible in order to complete your application.
- Once a routine application is processed and approved a permanent license will be issued.

For information with regard to the processing of this application and other concerns please contact the Board of Medical Examiners staff at (406) 841-2361 or (406) 841-2364 or email us at dlibsdmed@.mt.gov

PLEASE BE SURE TO REVIEW THE MONTANA LAWS AND RULES FOR PODIATRY ON OUR WEBSITE:
www.medicalboard.mt.gov

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AFFIX PHOTO HERE

PASSPORT SIZE

Application for Licensure as:

☐ **Doctor of Podiatric Medicine**

Allow 10 days from the date the Board has a complete routine application for licensure.

1. FULL NAME: _____
   Last First Middle
2. OTHER NAME(S) KNOWN BY _____
3. BUSINESS NAME _____
4. BUSINESS ADDRESS _____
   Street or PO Box # City and State Zip
5. HOME ADDRESS _____
   Street or PO Box # City and State Zip

   PREFERRED MAILING ADDRESS ☐ Business ☐ Home E-MAIL ADDRESS _____
6. TELEPHONE (____) _____ (____) _____ (____) _____
   Business Home Fax
7. SOCIAL SECURITY NUMBER _____ FOREIGN ID NUMBER _____
8. DATE OF BIRTH _____ PLACE OF BIRTH _____ ☐ MALE ☐ FEMALE
   City/State
9. LICENSE NAME _____
   (State your name as it should appear on the license if granted.)
10. Which exam did you take for initial licensure?

    ☐ NBPME ☐ PART I & II ☐ PART III (PMLEXIS) ☐ State Exam (indicate which state) _____

11. Do you intend to practice in the State of Montana? If yes, attach a brief explanation. ☐ Yes ☐ No
12. Have you ever previously applied for a license to practice in Montana? If yes, give date, and results. ☐ Yes ☐ No
13. Have you ever been denied licensure or the opportunity to take a professional licensing examination in any state or country? If yes, attach a detailed explanation. ☐ Yes ☐ No
14. Have you ever withdrawn an application for licensure? If yes, please give the state and reasons for withdrawal. ☐ Yes ☐ No

15. List all professional licenses you hold or **ever** have held. Verification must be sent directly to Montana from each state/province/territory.

State	License #	Issue Date	Expiration Date	License Method	Requested State Verification
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No
				☐Exam ☐ Endorse ☐Other	☐ Yes ☐ No

16. Has a licensing agency ever taken adverse or disciplinary action against your license? If yes, attach agency documents filed in the action including all complaints, initiating documents, orders, final orders, stipulations and consent and/or settlement agreements. ☐ Yes ☐ No

17. Have you ever voluntarily surrendered, cancelled, forfeited or failed to renew a license as a result of any of the following: having a complaint filed against you; entering into a consent agreement with respect to your license as a result of a complaint; during an investigation or during disciplinary proceedings? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

18. Has a complaint ever been made against you alleging unethical behavior, standard of care issues or unprofessional conduct? If yes, attach a detailed explanation. ☐ Yes ☐ No

19. Have you voluntarily or involuntarily surrendered any hospital privileges, health maintenance organization participation, Medicare/Medicaid privileges, or other privileges during a pending investigation, or in anticipation of an investigation, or had such privileges reprimanded, denied, restricted, suspended, placed on probation, revoked or subjected to other sanction or action? If yes, attach a detailed explanation identifying each occasion, the date and the substance of the allegations. ☐ Yes ☐ No

20. Has any legal or disciplinary action been filed against you, which relates to your propriety of, or your fitness to practice this profession (including malpractice, etc.)? If yes attach a detailed explanation of each instance including the date of the claim, name and address of party complaining, name and address of forum or court where claim was filed, docket or claim number and the substance of the allegations. ☐ Yes ☐ No

21. Have you ever voluntarily or involuntarily surrendered the privilege to prescribe or dispense any drug, including but not limited to controlled substances, or had such privileges investigated, denied, restricted, suspended, revoked or otherwise modified by any governmental agency, including but not limited to the Drug Enforcement Administration, any state licensing or disciplinary court or other entity? If yes, attach a detailed explanation. ☐ Yes ☐ No

22. Have you ever been expelled from or asked to resign from any professional organization or been censured by a professional organization of which you were a member? If yes, attach a detailed explanation. ☐ Yes ☐ No

23. Do you have criminal charges pending or have ever plead guilty, forfeited bond, or been convicted of a crime (including plea of no contest or deferred prosecution) whether or not an appeal is pending? You may omit: (1) payment of traffic misdemeanor fines and (2) charges or convictions prior to your 16th birthday. If yes, please attach a detailed explanation. ☐ Yes ☐ No

24. Do you have any physical or mental condition(s) which may have or has adversely affected your ability to practice this profession, including but not limited to a contagious or infectious disease involving serious risk to the public? If yes, attach a detailed explanation. ☐ Yes ☐ No

25. Have you used alcohol or any other mood-altering substance in a manner which may have or has adversely affected your ability to practice this profession? If yes, attach a detailed explanation. ☐ Yes ☐ No

26. PROFESSIONAL EDUCATION:

Name of University or College	City and State/Province/Territory	Dates Attended	Degree Earned

Name of Podiatry School	City and State/Province/Territory	Dates Attended	Degree Earned

Post-graduate Program	City and State/Province/Territory	Dates Attended	Diploma Received
			☐ Yes ☐ No
			☐ Yes ☐ No

27. Have you ever been certified by a Podiatric board? ☐ Yes ☐ No

Specialty/Certifying Board	Date Awarded or Re-certified

Surgical Residency Program	City and State/Province/Territory	Dates Attended	Diploma Received
			☐ Yes ☐ No
			☐ Yes ☐ No

(Please note that if you wish to practice Ankle Surgery in the State of Montana, you will need to complete the Ankle Surgery Certification Application, submit additional fees and be approved by the Board.)

28. Have you ever been denied specialty certification or failed to pass a specialty certification examination or portion thereof? ☐ Yes ☐ No

By whom?_____

Reason for denial?_____ Number of times failed_____

29. PRACTICE HISTORY: List **all** activities after podiatry school (other than those already set forth above) in chronological order, up to and including the present. Specify nature of activity; for example, private practice, hospital practice, vacation, school, private employment, etc. (If medical practice, indicate nature of practice.) **Account for all periods of time longer than 1 month**. **Indicate specific month and year for each activity.** Use supplemental sheet if necessary.

Location of Practice	Activity/Position	Inclusive Dates	Reason for Leaving

30. PROFESSIONAL & CHARACTER REFERENCES.

Please type or print names and addresses of three references at least two references must be licensed Podiatrists, who have known or associated with you for at least one year.

Name:
Address:
Telephone Number:

Name:
Address:
Telephone Number:

Name:
Address:
Telephone Number:

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice by anyone who might possess such information, to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____
Legal Signature of Applicant Date

Subscribed and sworn to before me this _____ day of _____, _____at

_____.
City/State

_____
Signature of Notary Public

SEAL _____
Printed Name of Notary Public

_____
For the State of

My commission expires _____,_____.

CERTIFICATE OF PODIATRY EDUCATION

(Please forward this form to the school of podiatry for certification of applicant's podiatry degree)

Do not make this endorsement unless applicant has affixed a PHOTOGRAPH and completed the AFFIDAVIT

Please complete and return form directly to: BOARD OF MEDICAL EXAMINERS, PO BOX 200513, HELENA MT 59620-0513

It is hereby certified that _____ of _____

Graduated from _____Location _____

Date Graduated _____, and is to the best of our knowledge is of good moral character.

(SEAL OF SCHOOL)

President, Dean or Registrar Signature _____

Date Certified _____

AFFIX PHOTO HERE

PASSPORT SIZE

AFFIDAVIT

I authorize the release of information concerning my education, training, record, character, license history and competence to practice by anyone who might possess such information to the Montana Board of Medical Examiners.

I hereby declare under penalty of perjury the information included in my application to be true and complete to the best of my knowledge. In signing this application, I am aware that a false statement or evasive answer to any question may lead to denial of my application or subsequent revocation of licensure on ethical grounds. I have read and will abide by the current licensure statutes and rules of the State of Montana governing the profession. I will abide by the current laws and rules that govern my practice.

_____ _____

Legal Signature of Applicant Dated

Subscribed and sworn to before me this _____ day of _____, _____at

_____.

City/State

_____

Signature of Notary Public

SEAL

_____

Printed Name of Notary Public

_____

For the State of

My commission expires _____,_____.

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TO THE APPLICANT

Please complete the identifying information and submit to:

DEA SALT LAKE CITY DO
DIVERSION GROUP
ATTN: CHAR MESSICK, R T
348 E S TEMPLE
SALT LAKE CITY, UT 84111-1202

Date: _____

To Whom It May Concern:

I am applying for a license to practice podiatry in the State of Montana. Please indicate on the lower portion of this form if there is any derogatory information on file against me. I hereby specifically authorize the release of any and all information concerning me, and agree to hold the DEA harmless from any liability for the disclosure of such information. Please send this form directly to the Montana Board of Medical Examiners. Thank you for your assistance.

Name: _____

Date of Birth: _____

DEA Registration Number: _____

Address where DEA Number is registered: _____

_____

_____ _____
Signature of Applicant Please Print Name

DEA RESPONSE:

MONTANA BOARD OF MEDICAL EXAMINERS

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Please complete the identifying information, enclose $40.00 in check or money order (payable to the Federation of Podiatric Medical Boards) and submit to:

Federation of Podiatric Medical Boards **Phone: 561-752-3735**
6551 Malta Dr
Boynton Beach FL 33437

Date:_____

The Montana Board of Medical Examiners requests a disciplinary search on me:

_____
Name

_____
Address

_____
City, State, Zip

_____
Date of Birth

_____
Social Security Number

_____
Medical School of Graduation and Location

_____
Date of Graduation

Please mail the response directly to the Montana Board of Medical Examiners.

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VERIFICATION OF MORAL/PROFESSIONAL CHARACTER

APPLICANT: Complete the upper portion of this form and mail to each of the character references you have listed in your application (page 6).

_____ _____
Legal Signature of Applicant Date

(Please Type or Print):
Name of Applicant: _____

Address: _____

This verification sent to: _____

CHARACTER REFERENCE: Please answer the following questions concerning the applicant's moral and professional character. This document is your authorization to release any and all information and opinions you have, favorable or otherwise, directly to the Montana Board of Medical Examiners. Your response will be kept confidential.

Name of reference: _____ Daytime phone: _____

Address: _____

Title/profession/position: _____

How long have you known the applicant? _____ In what capacity? _____

To your knowledge, does this applicant have any habits or practices that would adversely affect his/her professional activities? If your answer is "yes," please explain: _____
_____
_____
_____

Do you consider this applicant worthy of approval to practice as a podiatrist in Montana? _____

Please comment on the applicant's professional character, morals and ethics (attach additional sheet as needed): _____
_____
_____
_____

_____ _____
Signature of Reference Date

The Applicant and the Board thank you for your assistance.

VERIFICATION OF LICENSURE

THIS IS NOT AN ENDORSEMENT CERTIFICATION

PLEASE COMPLETE THIS SECTION OF THE FORM AND MAIL TO EACH STATE BOARD IN WHICH YOU ARE NOW OR HAVE EVER BEEN LICENSED TO PRACTICE AS A PODIATRIST. YOU MAY COPY THIS FORM AS MANY TIMES AS NEEDED. SOME BOARDS REQUIRE A FEE FOR THIS SERVICE.

STATE BOARD:

I am applying for a license to practice as a Podiatrist in the State of Montana. The Medical Board requires this form to be completed by each state wherein I hold or ever have held a professional/occupational license. This is your authority to release any information in your files, favorable or otherwise, **DIRECTLY** to the **BOARD OF MEDICAL EXAMINERS, P. O. BOX 200513, 301 SOUTH PARK AVENUE, HELENA, MT 59620-0513**. Your early response is appreciated.

_____ Name: _____
(Signature) (Please print)

Address: _____

My License Number is: _____

DO NOT DETACH -- THIS SECTION TO BE COMPLETED BY AN OFFICIAL OF THE STATE BOARD AND RETURNED DIRECTLY TO THE MONTANA STATE BOARD OF MEDICAL EXAMINERS

State of: _____

Full Name of Licensee: _____

License No. _____ Issue Date: _____

License is current? _____ If NO, explain _____

Has license been suspended, revoked, placed on probation or otherwise disciplined? _____

If YES, explain and attach documentation _____

_____

Has licensee ever been requested to appear before your Board? _____

If YES, explain _____

Derogatory information, if any _____

Comments, if any _____

Signed: _____

BOARD SEAL

Title: _____

State Board: _____ Date: _____